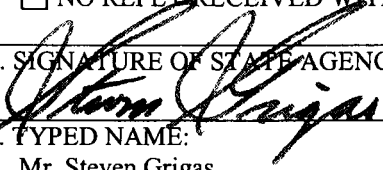



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 2004-022	2. STATE Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2004	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 2004      \$(2,077) b. FFY 2005      \$(8,246)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Exhibit I Version XII		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Exhibit I Version XI	
10. SUBJECT OF AMENDMENT: Outpatient Hospital Reimbursement			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Will forward when received.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Mr. Steven Grigas Acting Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308  Attention: Kay Newman	
13. TYPED NAME: Mr. Steven Grigas			
14. TITLE: Acting Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 7/22/04			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: July 26, 2004		18. DATE APPROVED: October 20, 2004	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2004		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Renard L. Murray, D.M.		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

**FLORIDA TITLE XIX OUTPATIENT HOSPITAL  
REIMBURSEMENT PLAN  
VERSION XII**

**EFFECTIVE DATE: July 1, 2004**

**I. Cost Finding and Cost Reporting**

- A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than 5 calendar months after the close of its cost reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Analysis, Cost Reimbursement.
- B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.
- C. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, Florida Administrative Code, F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new

Amendment: 04-022  
Effective: 07/01/04  
Supersedes: 2003-26  
Approved: 10/20/04

provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs (including outpatient fixed costs); or the budgeted rate in compliance with CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. and Section III of the Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

- D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35 - 413.50 (2000), further interpreted by the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.). and as further modified by this plan.
- E. Hospitals shall file a legible and complete cost report within 5 months, or 6 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.
- F. If a provider submits a cost report late, after the 5 month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 5 months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full

payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.

- G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS\_PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when: the capital stock of a corporation is sold; or partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.
- H. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c)(2000). For purposes of this plan, statistical records shall include the medical records of eligible Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent such as the Medicaid consent form, AHCA-Med Form 1005 as incorporated by reference in Rule 59G-5.080 (2), F.A.C.

- I. Records of related organizations as defined by 42 CFR 413.17 (2000) shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.
- J. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60 (2000). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the party making the request and the information requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor 15 days from receipt of the request by AHCA.
- K. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.  
  
Exception to the above mentioned time limit:  
  
The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.
- L. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's

administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

## **II. Audits**

### **A. Background**

A hospital common audit program has been established to reduce the cost of auditing submitted cost reports and avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital which shall serve the needs of all governmental programs reimbursing the hospital for services rendered.

### **B. Common Audit Program**

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII, and XIX. Under this agreement, the intermediaries shall provide AHCA the result of desk reviews and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

### **C. Other Hospital Audits**

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits. AHCA shall:

1. Determine the scope and format for on-site audits;

2. Desk audit all cost reports within 6 months after their submission to AHCA;
3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 (10/94) F.A.C;
4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.160 F.A.C;
5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;
6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 (10/94), F.A.C. and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60 (2000).

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audits using prior approved State plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.

2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely, overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.
3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Section 414.41 , Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in a suspension of the outpatient hospital from the Florida Medicaid Program.

F. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Rule 59-1.018(4), F.A.C., and Section 120.57, Florida Statutes,



for any or all adjustments made by AHCA. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

### **III. Allowable Costs**

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.35 - 413.50 (2000), the inpatient routine nursing salary cost differential, and the guidelines in the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.,) and as further modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

- A. Costs incurred by a hospital in meeting:
  - l. The definition of a hospital contained in 42 CFR 440.10 (2000) and 42 CFR 440.140 (2000) in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;

2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610 (2000); and
  3. Any other requirements for licensing under the State law which are necessary for providing inpatient hospital services.
- B. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321 (2000).
- C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Outpatient costs to Total Hospital Costs.
- D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.
- E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by the Agency or the Agency's authorized representative.
- F. Certain revenue centers are not reimbursed by Medicaid. Service rendered under these centers shall not be recorded on the Medicaid log and shall not be billed to

Medicaid. The list of covered revenue centers is attached as Appendix A.

Modifications of this list subsequent to the implementation of this plan shall appear in the Florida Medicaid Information System Update.

- G. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.101, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.
- H. Cost reports beginning January 1, 2005 and later shall not include any direct or indirect graduate medical education (GME) costs in any outpatient cost center. All GME costs are to be reported and/or allocated to inpatient cost centers.

#### **IV. Standards**

- A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205 (2000), this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.
- B. Reimbursement ceilings shall be established prospectively for each Florida county. Beginning with the July 1, 1993 rate period, additional ceilings based on the Target Rate System shall also be imposed. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as

general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings shall be established for and applied to general hospitals. Rural and specialized psychiatric hospitals shall be excluded from the calculation and application of the outpatient reimbursement ceilings. Statutory teaching, specialized, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 and 10 shall be included in the calculation but are exempt from the application of the outpatient reimbursement ceilings.

- C. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods, the reimbursement ceilings shall be effective from January 1 through June 30 and July 1 through December 31 of the appropriate years except as provided in G. below.
- D. Changes in individual hospital rates shall be effective from July 1 through December 31 and January 1 through June 30 of each year. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003.
- E. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims payment data from the